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A Phenomenological Exploration of Women's Utilisation of Maternal Healthcare Services in Bauchi State, Nigeria

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Abstract
Despite the government provision of maternal healthcare centres, the high maternal mortality rate in northern Nigeria has been an issue of concern. The level of utilisation of maternal healthcare centres has not been found encouraging. Hence, this study was carried out to explore the factors affecting women's utilisation of maternal health care services in Bauchi State, Nigeria. A descriptive phenomenology research design was adopted, while purposive and snowballing sampling techniques were used for participants' selection. Data were collected from 23 reproductive women, 5 married men, 2 skilled health workers, and 2 Traditional Birth Attendants (TBAs) through Focus Group Discussions (FGDs) and semi-structured interviews. The data collected were analysed with Colaizzi's-7 steps analytic technique using NVIVO Computer Assisted Qualitative Data Analysis Software (CAQDAS). Two themes and six clusters of themes emerged from the data analysis. The emerging themes were cultural belief systems and trust in the traditional healthcare system. The themes under the first theme were preference for female health workers, husband dominance, belief about death, and masculinity in pregnancy. The cluster of themes under the second theme was reliance on traditional treatment and support from TBAs' support. The community members were underutilising maternal healthcare centres. The results showed the need to pay more attention to awareness and sensitisation on the significance of healthcare in avoiding preventable deaths and promoting personal human responsibility on healthcare matters.
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1.Background

The World Health Organisation (WHO) estimates that approximately 536,000 women die annually from pregnancy-related causes, and nearly 10 million women experience pregnancy-related complications (WHO 2019). The record of all maternal mortality in developing nations (low and middle-income) is 94% (WHO 2021). The percentage shows that developing nations suffer mostly from maternal mortality. Many women in rural areas do not utilise maternal healthcare centres for antenatal and postnatal. Maternal outcomes are poor in Nigeria, with a low rate (36%) of women's delivery in Western maternal healthcare centres(Afolabi-Ojo 2019). With 576 deaths per 100,000 live births, Nigeria is among the top 16 countries in terms of maternal mortality(Afolabi-Ojo 2019). The utilisation of maternal health care services is a significant health issue to enable the survival of mothers and children. Utilising maternal healthcare services improves the health of mothers and their children before, during, and after birth and reduces maternal morbidity and mortality(Wanjala 2016). There are several implications of neglecting the maternal need for maternal healthcare.

Women can lose their lives after birth due to severe bleeding if not attended to. It was reported that 63% of reproductive mothers of 19,418 born children did not use postnatal care services, while approximately 42% of the study population did not receive postnatal care (Somefun & Ibisomi 2016). The study's findings also showed that non-utilisation of postnatal care services significantly correlates with antenatal care utilisation, distance, education, place of delivery, region, and wealth status. The reason for undertaking this study was to explore factors that influenced the utilisation of maternal healthcare centres in Bauchi State. Notably, it was reported that 41% of women did not deliver in Western maternal healthcare in Nigeria (Dahiru & Oche 2015). Nigeria, especially the northern part, has high maternal mortality rates (Kana *et al*. 2015).

Government provision of maternal healthcare and inadequate education about the need to utilise healthcare facilities has not resulted in a commensurate expectation whereby reproductive women are expected to utilise the facilities. The research gaps show a dearth of studies that have been carried out on the utilisation of maternal healthcare centres in Bauchi State. Most of the studies in Bauchi State were quantitative research, while few were available in qualitative studies. The few qualitative studies carried out covered home visits and general and child health, which differs from the objective of this study. Hence, there is a need to carry out a study to determine the utilisation of maternal healthcare in Bauchi State.

2. Literature Review

Maternal health is the period in women's lives encompassing conception, delivery, and the few months following childbirth (WHO 2019). However, Knaul et al. (2016) argue for a redefinition that would include all women regardless of the status of their childbearing. Knaul et al. (2016) claim that the description needs to consider various health risks women face and those associated with childbearing dangers or lifestyle choices.

2.1 Preference for home delivery

Home delivery's discretion is what informs unassisted delivery in some parts of Sub-Saharan Africa. Home delivery is a strong cultural belief alleged to be linked to quick delivery and protection for both mother and child from witchcraft (Caulfield *et al*. 2016). Abubakar et al. (2017) note that even though some women in Kano state in Northern Nigeria endorsed delivery by skilled workers, they would prefer this procedure within the confines of their homes for privacy. Interestingly, this can be compared to birthing conditions in the UK, where home births are one of the four options available to women carrying natural pregnancies (Hollowell *et al*. 2016). A perceived conducive atmosphere allegedly hastens childbirth (Caulfield *et al*. 2016). Kaba et al. (2016), in another study conducted in Ethiopia, remarked that the women in selected districts, including Oromia and Amhara, shared related views when they stated that delivering in familiar surroundings coupled with the prayers, cheers, and encouragement derived from home births were soothing and more comfortable. Likewise, in Eastern Cape, South Africa (Alabi *et al*. 2015) and some districts in Ethiopia (Kaba *et al.* 2016), the women preferred home delivery because they received help from relatives and neighbours. Home deliveries occurred with or without TBAs in Nigeria. This practice was quite common, especially for inexperienced mothers unable to identify early labour signs (Egharevba *et al*. 2017).

2.2 Preference for female health workers

The presence of male health workers during women's birthing process in rural areas in Northern Nigeria has been a major issue for a long time. It is evident in several studies (Ariyo *et al*. 2017); (Abubakar et al., 2017). In addition, several studies have established the presence of male health workers during delivery as a barrier against utilising maternal health services in northern Nigeria (Doctor *et al*. 2012; Omer *et al*. 2014; Fagbamigbe & Idemudia. 2015; Sharma *et al*. 2019).

Abor et al. (2011) also noted the role religious background plays in healthcare use. The Islamic faith of reproductive women is considered the major reason for the preference for the service of female health workers (Oyeniran *et al*. 2020). Sowunmi et al. (2016) explained women's difficulties when receiving healthcare from male health workers and is noteworthy that Muslim women do not utilise maternal health care services (Fapohunda & Orobaton 2013). The vulnerability due to exposure of women's intimate bodies to male healthcare workers is a secondary factor, which should be a primary factor. The issue is further exacerbated by the presence of male birth attendants (Caulfield *et al*. 2016). Mweemba et al. (2021) found that male health workers dominated maternal healthcare centres. Antenatal visits where male healthcare workers mostly attend to them could inform their conclusion on the number of numbers of healthcare workers, based on gender category in the healthcare centres. The preference for female health workers has also been traced to cultural beliefs. For example, there were reported cases in South Korea and Nigeria about women who chose not to utilise a western maternal health care service because they were not ready to undress before any male health workers because the women would only undress for their husbands (Okeshola & Sadiq. 2013; Kim *et al*. 2017). Similarly, in his view, Onasoga et al. (2014) traced this phenomenon to the mode of operation in some maternal health care centres. Such a mode of operation demands that women expose part of their body to male health workers during an examination, an act they found at variance with their religious values. Hence, they tend to refuse to utilise maternal health care while seeking an alternative where they are sure of women attending to them.

2.3 Husband supremacy

Husbands are regarded as the head of the family, the first agent of socialisation. There is a religious aspect to husbands' positions, jobs, and obligations to their spouses; they are regarded as the household's head and overseer, alluding to the holy book (Azuh, Fayomi, & Ajayi 2015). The husbands make the majority of family decisions while they provide direction for their families. Nigeria, especially the Northern parts, is patriarchal (Baba-Ari, Eboreime, & Hossain 2018). In the northern region, the husbands' role is often stretched to the extreme, where they dominate the family decision-making process. Male dominance allows husbands to make the most important decisions about their spousal healthcare and health-seeking behaviour; this evidence shows the husband's role significantly impacts the utilisation of maternal health services (Baba-Ari *et al.* 2018). In Nigeria, many Muslim women are not allowed to work, socialise, or leave their homes to shop without obtaining their husbands' permission. Their request is often not granted (Sinai *et al*. 2017), including requests for antenatal care. However, Solanke et al. (2015) argued that the reason behind the low patronage of maternity care in the Northern parts of Nigeria is related to a shortage of health personnel rather than support from their spouses.

Women's independence is not common among Hausa-Fulani and Kanuri/Bari-Bari ethnic groups of Northern Nigeria, due to adherence to long-standing traditional practices that promote male dominance. These practices have resulted in underutilising maternal healthcare services in developing countries (Hatcher *et al.* 2014). Chol et al. (2019) emphasised the importance of achieving the purpose of maternal healthcare services. These limitations on women's freedom and independence affect their utilisation of maternal healthcare centres. Conversely, when women are permitted, it helps them achieve many goals, including enhancement of personal goals and quality of family life. In a qualitative study in Zambia by Sialubanje et al. (2015), women's independence was found to be part of the factors that caused low patronage of the services of skilled healthcare workers in the maternal centres. Husband dominance significantly limits women's freedom to seek healthcare services (Shamaki, Yew, & Dahiru 2017). However, when women are not supported by their husbands, they can patronise the TBAs, whose services are cheap and free, depending on the situation.

2.4 The use of traditional herbs

Aborigo et al. (2014) highlighted in their report that some families disallowed visits to health facilities and evaded orthodox medicine in some parts of Ghana. Some women even administered drugs to themselves or consulted traditional healers. These women chose not to visit health facilities because they could use traditional herbs. Alabi et al. (2015) report that some women also use herbs in Cape Town, South Africa. The women of Masaka district in Uganda use herbs to prevent high body temperatures from averting miscarriages, among other things. There are similarities between these practices and those of Western culture (Kennedy *et al*. 2015). Interestingly, the cordial reception between the women and the vendors of these herbs, in addition to the payment mode, which could be credit-based or in-kind, discourages patronage of maternal health facilities (Atekyereza & Mubiru 2014). Likewise, women in Southeast Madagasgar are reported to consume traditional medicine to treat pain, inflamed abdomen, and fever during the postpartum period instead of visiting a maternal healthcare institution (Morris *et al*. 2014). Alabi et al. (2015) posit that some women in East Cape, South Africa take native medicine to hasten the delivery process. Similarly**,** Serizawa et al. (2014) add that the afterbirth ritual performed on women in Eastern Sudan deters them from taking tetanus injections during pregnancy. Antenatal care (ANC) is free in some parts of Nigeria (Fagbamigbe & Idemudia 2017), and this has produced favourable outcome (Galadanci *et al*. 2010). However, the tenacious belief in the efficacy of herbs makes them the most preferred means of treatment (Ojua *et al.* 2014). The researcher would like to propose that for most of these women, herbs are linked to a strong connection with their cultural roots. Even though this is most improbable in countries like the UK, where maternity care is relatively free (Hollowell *et al*. 2016) the inability to afford health care cannot fully account for using herbs.

3. Methods

Descriptive phenomenology was adopted to guide the study. Phenomenological research methods place the service user's voice at the centre of care delivery (Parkes & Freshwater 2015). Descriptive phenomenology helps a researcher to set aside biases and prejudices so that the participants' responses can reveal their shared experiences concerning utilising maternal healthcare services. Adopting descriptive phenomenology ensured that the researcher understood how reproductive women used maternal health services in the study area.

3.1. Study Location

This study was conducted in Nigeria's Bauchi State. Bauchi State is a state in Nigeria's North-East geopolitical zone. Kano and Jigawa line the north, Taraba and Plateau line the south, Gombe and Yobe line the east, and Kaduna lines the west of Bauchi State. The study's location was Birshi Neighbourhood Government Region in Bauchi State.

3.2. Study Participants

The participants comprised 23 reproductive women, 2 Traditional Birth Attendants, 2 Skilled Health Workers, and 5 male partners who were husbands to some women participants. The study was open to women between the ages of 15 and 49 who were pregnant, had a miscarriage, or had at least one or more children. Married men aged 20 to 65 were selected because of the patriarchal nature of Nigerian society; exploring the opinion of men regarding a factor that influences women in the utilisation of maternal was also considered vital.

3.3. Data Collection

The researcher utilised semi-structured interviews and Focus Group Discussions (FGDs) for data collection. It is insufficient to use only interviews to discover phenomena in phenomenological studies (Paley 2014). Hence, combinations of other data collection methods were suggested by other researchers (Frechette et al., 2020). The researcher conducted a Focus Group Discussion (FGD) with 8 women from different families, sharing similar characteristics, such as pregnant women in their first and second trimesters, first-time mothers, and multi-para.

The following group of people were interviewed: five (5) men, seven (7) women, two (2) healthcare workers (1 male and 1 female), and two (2) TBAs, who were both women.

3.4: Data Processing and Analysis

The audio files from FGD and the interview sessions were transcribed and stored in word-processing files with passwords. Colaizzi's descriptive phenomenological data analysis strategy was adopted to analyse the data collected for the study(Colaizzi 1978). Colaizzi's strategy in descriptive phenomenology is used to produce a comprehensive description of the phenomenon under study. Hence, it was used to elicit an in-depth description of the lived experiences of reproductive women using maternal health services in Bauchi State, Nigeria. The data collected were analysed with Computer Assisted Qualitative Data Analysis Software (CAQDAS), NVIVO 12.

3.5: Ethical Considerations

Ethical clearance was obtained from the Bauchi State Health Research Ethics Committee (BASHREC) to access the study sites. BASHREC granted the researcher clearance approval to proceed with the data collection. Ethical approval from the University of Northampton was gained in full. The UK process assisted with generating a participant information sheet (PIS) and a consent form to be utilised by the researcher to conduct this study.

4. Results

4.1. Socio-demographic Characteristics of Participants

The results showed that all sampled TBAs and women of reproductive age were females. The information concerning the religious status of the participants shows that most of them were Muslims. The result also showed that most of the participants had Islamic educational qualifications, none of the women participants had had tertiary education, most women participants and health workers belong to the 31-45 age group, most male participants belong to the 46-60 age group, the family size of most of the part participants was between 6-10, and he majority, 16 women participants, was multigravida.

Table 1: Demography of the Participants

Demography	**Reproductive women**	**Health Workers**	**TBAs**	**Male Participants (Husbands)**	**Total**
Gender					
Male	0	1	0	5	**6**
Female	23	1	2	0	**26**
Total	**23**	**2**	**2**	**5**	**32**
Religion:					
Christianity	3	0	0	0	**3**
Islam	20	2	2	5	**29**
Total	**23**	**2**	**2**	**5**	**32**
Education Qualification:					
Primary Education	3	0	0	2	**5**
Secondary Education	3	0	0	0	**3**
Tertiary Education	0	2	0	0	**2**
Islamic Education	10	0	2	3	**15**
No Education	7	0	0	0	**7**
Total	**23**	**2**	**2**	**5**	**32**
Age group:					
15-30 years	8	0	0	0	8
31-45 years	15	2	0	0	17
46-60 years	0	0	1	3	4
61-75 years	0	0	1	2	3
Total	**23**	**2**	**2**	**5**	**32**
Family size:					
Less than 5	1	1	0	0	2
6-10	12	1	0	0	13
11-15	10	0	0	0	10
16-20	0	0	0	2	2
21-25	0	0	0	2	2
26-30	0	0	2	1	3

Total	**23**	**2**	**2**	**5**	**32**
Women Pregnancy Status					
Primigravida	1	-	-	-	-
Pregnant	6	-	-	-	-
Multigravida	16	-	-	-	-
Total	**23**	-	-	-	-

4.2-Pregnancy related belief

The participants identified some pregnancy-related beliefs that affected their utilisation of maternal healthcare.

4.2.1-Masculinity in pregnancy

The participants' experience captured women using natural strength to deliver their babies without visiting maternal health care.

A male participant expressed his preference for the delivery of his wives at home with the assistance of a Traditional Birth Attendant (TBA):

A male (Participant 6) and a female participant (Participant 12) affirmatively expressed their preference for home delivery.

A pregnant woman emphasised her belief that there was no need for formal maternal health care services. Her reason was traceable to God, and through the use of solutions nature has provided to help for a successful pregnancy period:

> *'In fact, women believe that God has blessed every woman with all the needed strength and some natural solutions (mainly in the form of herbs) to keep their pregnancy without the need for any artificial support from any healthcare facility* (Participant 14)

Another participant expressed her view on the sufficiency of women's strength to endure various experiences during pregnancy that these natural herbs support community resources to ensure pregnant women give birth without attending formal maternal care for child delivery:

> *'We believe that every woman on earth is blessed with sufficient strength to endure everything that comes with pregnancy, and we are also blessed with natural herbs to serve as a medicine when we utilise them well. We have herb experts in this community who are skilled and have the needed experience in utilising these herbs. We use those people as a guide on how to make the most of the abundant natural herbs we are endowed with* (Participant 15)

4.2.2: Belief about death

Some participants' beliefs about death showed the indispensability of death regardless of their responsibility, including health issues. According to a participant:

> *'Once it is time for somebody to die, any mortal can do nothing to prevent that.* (Participant 19)

On the other hand, a male participant, who corroborated the belief about death, believed that such an opinion had resulted in some patients' premature deaths:

> *'When a patient dies, they will say it was the person's time to die; no matter what they would have done, it would not have been enough to save their life. This belief has led many people to their early graves, though the practice has started changing* recently (Participant 8).'

4.3 Preference for Traditional Healthcare

This sub-theme captures why participants preferred traditional healthcare over institutional delivery.

4.3.1 Preference for female health workers,

Some male participants considered male health workers attending to their wives unacceptable and at variance with their cultural beliefs. The male participants had the imagination of opening the sensitive parts of their women, which they considered an exclusive part for their husbands:

> *'The major area of great concern to us is the practice where somebody you don't know would take your wife inside a particular room and undress her to investigate or observe a specific aspect of her body. This is a great taboo in our beliefs and culture in this community; whenever my wife comes back from the healthcare centre, I always feel she must have opened a sensitive part of her body to be observed by an unknown person, which implies that that person has defiled her.* (Participant 6)

A male participant questioned male workers attending to his wife and, thus, preferred the need to maintain gender balance by allowing female health workers to attend to female patients. According to him:

> *'The one that concerns me the most is when a male staff investigates my wife by asking her to expose certain body parts. This is not acceptable. Why must a male staff carry out the investigation?'* (Participant 7).

A male health worker traced the dominance of male health workers as a significant issue affecting the utilisation of maternal healthcare services because of a tendency to lure women into an evil act:

'*We find it uncomfortable that most medical workers at the healthcare centres are men. It would be hard for a woman to resist any evil attempt by such a well-educated, well-dressed, good-looking, and intelligent man. This is why we find it difficult to encourage our women from accessing such medical facilities…'* (Participant 8)

In addition, the male participant expanded on this subject matter, as he cited a case where one of the health workers snatched someone's wife in this process:

'…Malam Saidu's wife was snatched by a medical worker a few years ago…' (Participant 8)

Male workers were believed to have a gender advantage because they could travel anywhere at any time, unlike their married female counterparts:

'*On the other side, the government does not send women nurses or female health workers to remote areas away from their husbands; this is why most health workers in remote areas are mostly men.' (*Female Health Worker, Participant 1)

4.3.2 Reliance on Traditional Healthcare

The participants emphasised a complete reliance on traditional caregiving due to a high level of trust. A Traditional Birth Attendant shared a story of pregnant women's patronage and concluded their comfort with traditional healthcare management:

'It was amazing how women kept trooping with either babies or pregnancy for treatment, and different complaints prescribed different solutions. And the community's people seem comfortable with traditional health management (Participant, TBA 1).

A participant appreciated the strength and applauded the skills of the traditional health workers in providing a solution to peoples' problems:

*'However, there are areas where traditional medicine is effective and not dangerous. In those areas, I think I will applaud the traditional medical caregiver for their skills in identifying such remedies' (*Participant, TBA 2*)*

A male participant shared that their community's long-time reliance was based on the effectiveness of the traditional healthcare service providers:

'*People naturally seek help when they cannot provide it. In our case, in this community, the traditional medical healthcare service providers have been doing so well that we do not need to go elsewhere to seek any assistance whatsoever. We rely entirely on them for our medical needs. Once a woman conceives, an herbal solution is given…."* (Male. Participant 11)

On the other hand, another participant emphasised that reliance on herbal treatment was not an all-time solution but depended on the nature of the ailment under treatment. According to her:

'I cannot say there is nothing as such, but we do not rely entirely on herbal solutions to every pregnancy-related problem because there is enlightenment' This is why one of my children was delivered in the hospital' (FGD2, Female, Participant 2).

4.4: Support System

This sub-theme captures the state of the health support system available to the participants in their community.

4.4.1.TBA's support

The participants considered TBAs as assets to their communities, while their services were deemed worth patronising because of the track records of their effectiveness.

A male participant shared his confidence in the service of the TBAs to the point of releasing their wives to the TBAs for health care, including home delivery:

'We have the TBAs who look after our women during pregnancy and delivery. The TBAs also look after them after delivery if there are complications. Apart from the TBAs, our mothers have experience in this area, so we leave everything for the women to handle. My attention is only needed when there is a need to provide anything regarding money. Sometimes, they go for Antenatal Care (ANC), but delivery is done at home.' (Participant I)

Another male participant emphasised the patronage of the TBAs based on the nutritional help they provide for pregnant women.

'My wife does go to the maternity for antenatal care. We follow the advice of health professionals. However, we know both traditional and modern types of food are prepared to provide blood and nutrition to women…." (Participant 10)

Similarly, another TBA shared provision of traditional special medication inherited from their genealogy and helping pregnant women to have a safe delivery:

'Pregnant women are like babies; they do need special attention. I provide sufficient food and some traditional medication we inherited from our parents and passed down to them from our forefathers. We also relieve the pregnant wife from hard labour and other activities in the house as the pregnancy advances…' (Participant 11)

A participant appreciated the availability of the traditional caregiving system in their communities and adjudged its sufficiency in the management of illness:

'Many of us believe that God Almighty has endowed us with a good and reliable traditional caregiving system to help us manage our illnesses. Since this caregiving system has not failed us in any way, and it is something that was passed on to us by our parents, we felt it would not be fair to play with the age-long tradition, but we would continue to uphold this in our time' (FGD, Female Participant 15)

The activities of the traditional health attendants, which patients found relevant, trusted and without fault make them earn the loyalty of the community members:

'*Most of the time, the TBAs do some chants to help the pregnant woman. However, it is a practice with no scientific bearing and will not be approved medically. Those women who enjoy the services will never go to the modern healthcare centre for any help because they seem to give their whole self to the tradition too much that they cannot find any fault with the traditional practice' (Participant 9).*

4.4.2 Husband Supremacy

The finding showed that husbands dominate every home decision, while there was no opportunity for the wives to engage their husbands in making decisions about family matters and other issues.

According to a female participant,

'The other problem is that it is an abomination to see a man and his wife sitting together to discuss any issue. The wife's work is to report any problem to her husband while the husband decides how the problem is handled without her contribution. In such a situation, educating the women will have little or no effect on the family accessing the healthcare services, since the wife does not influence the husband' (Participant 2)

The movement of women in attending any event or going out that warranted leaving their premises was subject to ratification by their husbands, while such request was not always guaranteed to be approved:

'A woman cannot go outside her home without her husband's full knowledge and consent. This is a serious problem because when the women ask permission from their husbands, they have the right to either accept or decline.' (Participant 3)

The extension of male dominance stretched to the point that the outcome of their wives' requests to leave their premises for one reason or the other, if found unfavourable, could not be questioned, including health issues:

*'On the other hand, the wife does not have the right to either ask why he refused her permission or make an effort to explain to the husband why she needs to go out to any healthcare centre for healthcare services' (*Participant 5)

The findings showed that women were not financially supported by their husbands. Hence, such women lacked the financial power to pay for medical bills since their husbands did not provide money to meet their medical bills:

'*The other issue is that we do not have the support of our husbands when we want to go to healthcare centres. The husbands discourage us by refusing to give us transport money and some extra funds to help cater to the other medical bills we may incur at the healthcare centres.*' (Interview, Male Participant 2)

5. Discussion

This study explored the factors that caused the underutilisation of maternal health services among reproductive women in Bauchi State. The study showed found that self-delivery was a sign of strength among women. Self-delivery is why pregnant women desire to deliver their babies home without visiting a formal maternal health care centre. The finding agrees with the position of Shamaki and Buang (2019), who affirmed this practice among pregnant women seeking assistance afterwards for cleaning and placenta removal. The preference for home delivery was found in this study, as shared by the male participants. This finding agrees with Teklesilasie and Deressa (2020), who found many husbands preferred home delivery. The reason was based on the perception of child delivery as a normal process when women were expected to display their endurance as long as they were not sick during the pregnancy. Women are believed to have sufficient natural strength to endure the pregnancy experience. This finding reveals a cultural appreciation of women's roles in their community. However, this finding may encourage home delivery among pregnant women, which could result in the underutilisation of maternal health care. Home delivery is not without some complications. The experiences accompanying home delivery are not palatable and may eventually lead to losing the baby and the mother. In advanced nations where medical personnel are readily available upon request, home delivery is risky in rural areas due to the scarcity of medical personnel.

The study's finding on belief about death agrees with Sharma et al. (2017) who noted the northern Nigerians' belief that God controls every phenomenon's outcome, regardless of human contribution. The authors emphasised the general belief among the northern Nigerians on the inevitability of death but did not include the preventability of death. The northerners believe in God's predestination of death, even if the victim was the one

that caused the death. They believe that the human experience of adverse occurrences can lead to death, and such occurrences are unstoppable. Hence, the experiences of adverse co-occurrences are accepted as fate and unpreventable. As it stands, this finding should drive people to seek safe health care. However, holding to beliefs that tend to make people lose their sense of responsibility must be checked. Adherents of various religions use health care differently because they spiritualise health situations when deciding when to seek medical help or Western medicine (Adeyemi 2020). There are health provisions made available in the maternal health centres. Failure to maximise these provisions may result in premature delivery or the death of pregnant women.

The study showed the presence of male workers attending to female patients was a source of concern, while women don't want to utilise maternal healthcare facilities. The presence of male health workers during women's births has long been a major issue in Northern Nigeria (Ariyo *et al*. 2017). The male partners who were husbands to these women did not appreciate the mode of operation in the health centres, where male health workers are allowed to attend to female patients who are wives to their husbands. They considered it a violation of their privacy on the premise that the sensitive part of a woman should be solely seen by her husband or by female health workers of the same gender as the women receiving health care. They questioned the service of the male health workers regardless of their effort and the quality of service they rendered. In this study, the gender dichotomy concern was raised by the husbands, unlike in other studies, where the issue was raised by women (Okeshola & Sadiq 2013). The findings of Umar (2017) agree with the findings of this study regarding gender dichotomy. The husbands were comfortable and at rest when skilled health workers of the same gender examined their wives. To these husbands, abiding by cultural norms and personal jealousy seemed better than other health considerations and benefits. It could be explained that the husbands may have prevented their wives from attending the health care centres because of the limited number of female health workers, causing them to opt for traditional health care. Resorting to the patronage of traditional health care was a convenient alternative since gender dichotomy was the main issue. The TBAs are women, unlike in formal health care in rural areas where skilled male health workers dominate. Therefore, the issue of TBAs examining their wives would not be an issue, an interaction that was culturally and religiously acceptable to the husbands.

The findings showed that traditional medicine was more powerful and efficacious than the formal maternal health care system. The finding was one of the reasons women patronised the TBAs. Traditional medication involves using herbs, concoctions, and holy water, among others, to ease the childbirth experience of pregnant women. This finding agrees with some findings from other sub-Saharan countries, where Sumankuuro (2018) found how pregnant women were being cleansed with special and herbal concoctions. It could be explained that these traditional medications are not as costly as drugs in the formal maternal health care centre. These findings show the place of traditional medicine, which has served as an alternative to Western medicine. Government and NGOs could partner with these local producers to standardise the traditional medicine that has proved productive to the community members over the years. The standardisation process implies that more medicines tested and trusted could be made available to the list of existing medicines if the traditional medicines successfully pass through scientific tests. Other likely benefits of this process are that the prices of these medicines would be cheaper than the imported ones because industries producing medicines can be cited in the local areas because of the low cost of production.

The study's findings show that the TBAs' services were highly patronised by the community members. The pregnant women in the community did opt for the services of the TBAs for child delivery. The finding aligns with Ekeopara and Ugoha (2017) who found high patronage of the TBAs because of their prominence in the community. The TBAs' ability to provide cultural rituals when needed was considered an edge over formal maternal health care. This study's findings regarding the TBAs show how they were valued and respected in the community. Many families placed their trust in the healthcare services offered by the TBAs. Hence, the government must train them to provide maternal healthcare services within their knowledge since they are a major community stakeholder. Pregnant women can enjoy more attention and friendliness because of the workloads of the TBAs. There is no doubt of the testimony of safe deliveries over the years. However, there are better ways of doing the same thing they have done over the years. The existence of health centres is to provide professional health services for people. The TBAs' mode of operation is not regulated like that of a formal system where health workers have been professionally trained. Several studies have revealed the challenges of patronising the activities of the TBAs. These findings show the patronage of TBAs is a concern that should be checked for a life purpose despite their positive attributes. Government and NGOs could provide necessary training and tools for the TBAs. The TBAs in the communities must be registered without financial implications and trained to provide some assistance services to skilled healthcare workers.

From this study, the husband's position was found to be holy within the cultural settings. Husbands are significant decision-takers, and their words are usually considered final. It was found that no provision was made for women's autonomy in the cultural settings, an issue affecting women's maternal care. This finding agrees with Baba-Ari, Eboreime, and Hossain (2018), who found the influence of the husband's position on their wives utilising the maternal healthcare service. In similar settings, husbands are seen as a force with social and

economic power that can facilitate their wives' access to maternal health services (Aborigo *et al.* 2018). The husbands' position implies they are the major determinant of the health-seeking behaviour of their wives. Their wives see These husbands as 'unquestionable' on any decision. The findings showed that not all women who utilised traditional healthcare planned to do so. However, their husbands' lack of permission and support gave them no option but to utilise alternative healthcare to Western healthcare services. This study shows the limitations of women in making decisions of their own volition without their husband's approval. This finding may increase the existing poverty level in the region unless there is a change in the husbands' perceptions and attitudes regarding this matter. This finding may endanger the wives' lives, especially concerning pregnancy and child delivery issues. Husbands' refusal to grant permission to their wives to attend the health centre is not without some health implications. Dependence on traditional health care does not always work out. There are many health issues beyond the power of the TBAs.

6. Conclusion and Recommendations

This study highlights specific cultural-related issues to the utilisation of maternal care. The study highlights the prestige attached to self-delivery without considering institutional delivery. The study amplifies the indispensability of death without corresponding human responsibility to guide against preventable death. This practice hinders community members from seeking help in the formal health care centre when needed. Both male and female partners preferred female health workers to care for their wives during childbirth and health consultations. The government, Non-Governmental Organisations, and enlightened individuals in the community should increase the level of health advocacy in Northern Nigeria with the readiness of the community members to attend maternal healthcare when necessary. Health advocacies can gradually change the narrative concerning the preference for female health workers due to cultural factors. The seminar would let male partners be privy to necessary health information about pregnancy and child delivery. Training and retraining of the TBAs will increase the safe delivery rate and the demand for additional trained healthcare service providers in rural areas. TBAs should be trained to clean and disinfect delivery tools for hygienic practices. Community awareness campaigns of the dangers of indiscriminate herbal medicine use during pregnancy should be carried out in the community by healthcare managers and other advocacy groups. The sensitisation and awareness will enable the community to understand the side effects of traditional medicine, despite its acclaimed effectiveness.

References

Abor, P. A., Abekah-Nkrumah, G., Sakyi, K., Adjasi, C. K. D., & Abor, J. (2011). The socio-economic determinants of maternal health care utilization in Ghana. *International Journal of Social Economics*, *38*(7), 628–648. https://doi.org/10.1108/03068291111139258

Aborigo, R. A., Moyer, C. A., Gupta, M., Adongo, P. B., Williams, J., Hodgson, A., Allote, P., & Engmann, C. M. (2014). Obstetric danger signs and factors affecting health seeking behaviour among the Kassena-Nankani of Northern Ghana: a qualitative study. *African Journal of Reproductive Health*, *18*(3), 78–86.

Aborigo, R. A., Reidpath, D. D., Oduro, A. R., & Allotey, P. (2018). Male involvement in maternal health: Perspectives of opinion leaders. *BMC Pregnancy and Childbirth*, *18*(1), 1–10. https://doi.org/10.1186/s12884-017-1641-9

Abubakar, S., Adamu, D., Hamza, R., & Galadima, J. B. (2017). *Review of Quality of Care Determinants of Home Delivery among Women attending Antenatal Care in Bagwai Town , Kano Nigeria*. *21*(December), 73–79. https://doi.org/10.29063/ajrh2017/v21i4.8

Adeyemi, N. . (2020). Socio-Demographic Barriers to Utilization of Modern Maternal Healthcare Services (MHCS) among reproductive age women utilizing the services of Traditional Birth Attendants (TBAS) in Southwestern, Nigeria. *The Nigerian Journal of Medical Sociology*, *2*(1), 32.

Afolabi-Ojo, G. J. (2019). Nigeria. *Energy in the Transition from Rural Subsistence*, 143–157. https://doi.org/10.4324/9780429042669-8

Alabi, A. A., O'Mahony, D., Wright, G., & Ntsaba, M. J. (2015). Why are babies born before arrival at health facilities in King Sabata Dalindyebo Local Municipality, Eastern Cape, South Africa? A qualitative study. *African Journal of Primary Health Care and Family Medicine*, *7*(1). https://doi.org/10.4102/phcfm.v7i1.881

Ariyo, O., Ozodiegwu, I. D., & Doctor, H. V. (2017). *The influence of the social and cultural environment on maternal mortality in Nigeria : Evidence from the 2013 demographic and health survey*. 1–19.

Atekyereza, P. R., & Mubiru, K. (2014). Influence of pregnancy perceptions on patterns of seeking antenatal care among women in reproductive age of Masaka district, Uganda. *Tanzania Journal of Health Research*, *16*(4), 1–12. https://doi.org/10.4314/thrb.v16i4.8

Azuh, D., Fayomi, O., & Ajayi, Lady. (2015). Socio-Cultural Factors of Gender Roles in Women's Healthcare Utilization in Southwest Nigeria. *Open Journal of Social Sciences*, *03*(04), 105–117. https://doi.org/10.4236/jss.2015.34013

Baba-Ari, F., Eboreime, E. A., & Hossain, M. (2018). Conditional cash transfers for maternal health interventions: Factors influencing uptake in North-Central Nigeria. *International Journal of Health Policy and Management*, *7*(10), 934–942. https://doi.org/10.15171/ijhpm.2018.56

Caulfield, T., Onyo, P., Byrne, A., Nduba, J., Nyagero, J., Morgan, A., & Kermode, M. (2016). Factors influencing place of delivery for pastoralist women in Kenya: A qualitative study. *BMC Women's Health*, *16*(1), 1–11. https://doi.org/10.1186/s12905-016-0333-3

Chol, C., Negin, J., Agho, K. E., & Cumming, R. G. (2019). Women's autonomy and utilisation of maternal healthcare services in 31 Sub-Saharan African countries: Results from the demographic and health surveys, 2010-2016. *BMJ Open*, *9*(3), 1–9. https://doi.org/10.1136/bmjopen-2018-023128

COLAIZZI, P. (1978). Psychological research as the phenomenologist views it. *Existential Phenomenological Alternatives for Psychology*, 48–71. https://cir.nii.ac.jp/crid/1570572700116172544

Dahiru, T., & Oche, O. M. (2015). Determinants of antenatal care, institutional delivery and postnatal care services utilization in Nigeria. *Pan African Medical Journal*, *21*, 1–17. https://doi.org/10.11604/pamj.2015.21.321.6527

Doctor, H. V., Findley, S. E., Ager, A., Cometto, G., Afenyadu, G. Y., Adamu, F., & Green, C. (2012). Using community-based research to shape the design and delivery of maternal health services in Northern Nigeria. *Reproductive Health Matters*, *20*(39), 104–112. https://doi.org/10.1016/S0968-8080(12)39615-8

Egharevba, J., Pharr, J., & Wyk, B. Van. (2017). *Factors Influencing the Choice of Child Delivery Location among Women Attending Antenatal Care Services and Immunization Clinic in Southeastern Nigeria*. *6*(1), 82–92. https://doi.org/10.21106/ijma.213

Ekeopara, C. ., & Ugoha, A. M. . (2017). The Contributions of African Traditional Medicine to Nigeria ' s Health Care Delivery System . *Journal Of Humanities And Social Science*, *22*(5), 32–43. https://doi.org/10.9790/0837-2205043243

Fagbamigbe, A. F., & Idemudia, E. S. (2015). Barriers to antenatal care use in Nigeria: Evidences from non-users and implications for maternal health programming. *BMC Pregnancy and Childbirth*, *15*(1). https://doi.org/10.1186/s12884-015-0527-y

Fagbamigbe, A. F., & Idemudia, E. S. (2017). Wealth and antenatal care utilization in Nigeria: Policy implications. *Health Care for Women International*, *38*(1), 17–37. https://doi.org/10.1080/07399332.2016.1225743

Fapohunda, B. M., & Orobaton, N. G. (2013). *When Women Deliver with No One Present in Nigeria : Who , What , Where and So What ? 8*(7). https://doi.org/10.1371/journal.pone.0069569

Frechette, J., Bitzas, V., Aubry, M., & Kilpatrick, K. (2020). *Capturing Lived Experience : Methodological Considerations for Interpretive Phenomenological Inquiry*. *19*, 1–12. https://doi.org/10.1177/1609406920907254

Galadanci, H. ., Idris, S. ., Sadauki, H. ., & Yakasai, I. . (2010). *Programs and Policies for Reducing Maternal Mortality in Kano State , Nigeria : A Review*. *2010*(3), 31–36.

Hatcher, A. M., Woollett, N., Pallitto, C. C., Mokoatle, K., Stöckl, H., MacPhail, C., Delany-Moretlwe, S., & García-Moreno, C. (2014). Bidirectional links between HIV and intimate partner violence in pregnancy: Implications for prevention of mother-to-child transmission. *Journal of the International AIDS Society*, *17*, 1–9. https://doi.org/10.7448/IAS.17.1.19233

Hollowell, J., Li, Y., Malouf, R., & Buchanan, J. (2016). Women ' s birth place preferences in the United Kingdom : a systematic review and narrative synthesis of the quantitative literature. *BMC Pregnancy and Childbirth*, 1–17. https://doi.org/10.1186/s12884-016-0998-5

Kaba, M., Bulto, T., Tafesse, Z., Lingerh, W., & Ali, I. (2016). Sociocultural determinants of home delivery in Ethiopia: A qualitative study. *International Journal of Women's Health*, *8*, 93–102. https://doi.org/10.2147/IJWH.S98722

Kana, R. K., Maximo, J. O., Williams, D. L., Keller, T. A., Schipul, S. E., Cherkassky, V. L., Minshew, N. J., & Just, M. A. (2015). Aberrant functioning of the theory-of-mind network in children and adolescents with autism. *Molecular Autism*, 1–13. https://doi.org/10.1186/s13229-015-0052-x

Kennedy, C., O'Reilly, P., Fealy, G., Casey, M., Brady, A. M., McNamara, M., Prizeman, G., Rohde, D., & Hegarty, J. (2015). Comparative analysis of nursing and midwifery regulatory and professional bodies' scope of practice and associated decision-making frameworks: A discussion paper. *Journal of Advanced Nursing*, *71*(8), 1797–1811. https://doi.org/10.1111/jan.12660

Kim, I. J., Kim, S. H., & Sohn, S. K. (2017). Societal perceptions of male nurses in South Korea: A Q-methodological study. *Japan Journal of Nursing Science*, *14*(3), 219–230. https://doi.org/10.1111/jjns.12152

Knaul, F. M., Langer, A., Atun, R., Rodin, D., Frenk, J., & Bonita, R. (2016). Rethinking maternal health. *The Lancet Global Health*, *4*(4), e227–e228. https://doi.org/10.1016/s2214-109x(16)00044-9

Morris, J. L., Short, S., Robson, L., & Andriatsihosena, M. S. oafal. (2014). Maternal health practices, beliefs

and traditions in southeast Madagascar. *African Journal of Reproductive Health*, *18*(3), 101–117.

Mweemba, C., Mapulanga, M., Jacobs, C., Katowa-Mukwato, P., & Maimbolwa, M. (2021). Access barriers to maternal healthcare services in selected hard-to-reach areas of zambia: A mixed methods design. *Pan African Medical Journal*, *40*. https://doi.org/10.11604/pamj.2021.40.4.28423

Ojua, T. A., Atama, C., Igwe, J., Obekezie, D. S., & Ugwu, C. (2014). *Socio-Cultural Implications of Exclusive Bio-Paternity System on the Health of Women of Owukpa Community in Benue State , Nigeria*. *July*, 70–77. file:///C:/Users/USER/AppData/Local/Mendeley Ltd./Mendeley Desktop/Downloaded/Ojua et al. - 2014 - Socio-Cultural Implications of Exclusive Bio-Paternity System on the Health of Women of Owukpa Community in Benue S.pdf

Okeshola, F. B., & Sadiq, I. T. (2013). *Determinants of Home Delivery among Hausa in Kaduna South Local Government Area of Kaduna State , Nigeria*. *3*(5), 78–85.

Omer, K., Afi, N. J., Baba, C., Adamu, M., Malami, S. A., Oyo-ita, A., Cockcroft, A., & Andersson, N. (2014). *Seeking evidence to support efforts to increase use of antenatal care : a cross-sectional study in two states of Nigeria*. 1–10.

Onasoga, A. O., Osaji, T. A., Alade, O. A., & Egbuniwe, M. C. (2014). Awareness and barriers to utilization of maternal health care services among reproductive women in Amassoma community, Bayelsa State. *International Journal of Nursing and Midwifery*, *6*(1), 10–15. https://doi.org/10.5897/ijnm2013.0108

Oyeniran, Y. A., Adeyeye, O., & Sowunmi, C. O. (2020). Evaluation of patient satisfaction with the quality of maternal and child services of health facilities in Ile-Ife, Osun State. *African Journal of Midwifery and Women's Health*, *14*(3), 1–14. https://doi.org/10.12968/ajmw.2019.0004

Paley, J. (2014). Heidegger, lived experience and method. *Journal of Advanced Nursing*, *70*(7), 1520–1531.

Parkes, J., & Freshwater, D. (2015). Meeting the needs of women in secure mental health: a conceptual framework for nurses. *Journal of Research in Nursing*, *20*(6), 465–478. https://doi.org/10.1177/1744987115599670

Serizawa, A., Ito, K., Algaddal, A. H., & Eltaybe, R. A. M. (2014). Cultural perceptions and health behaviors related to safe motherhood among village women in Eastern Sudan: Ethnographic study. *International Journal of Nursing Studies*, *51*(4), 572–581. https://doi.org/10.1016/j.ijnurstu.2013.08.007

Shamaki, M. A. (2019). *Sociocultural practices in maternal health among women in a less developed economy : An overview of Sokoto State , Nigeria Sociocultural practices in maternal health among women in a less developed economy : An overview of Sokoto State , Nigeria*. *November 2014*.

Shamaki, M. A., Yew, V. W. C., & Dahiru, M. K. (2017). Analysing Barriers to Accessing Maternal Healthcare Systems in Developing Countries: A Case of Sokoto-Northern Nigeria. *Mediterranean Journal of Social Sciences*, *8*(1), 299–305. https://doi.org/10.5901/mjss.2017.v8n1p299

Sharma, V., Leight, J., AbdulAziz, F., Giroux, N., & Nyqvist, M. B. (2017). Illness recognition, decision-making, and care-seeking for maternal and newborn complications: a qualitative study in Jigawa State, Northern Nigeria. *Journal of Health, Population, and Nutrition*, *36*(Suppl 1), 46. https://doi.org/10.1186/s41043-017-0124-y

Sharma, V., Leight, J., Giroux, N., Abdulaziz, F., & Nyqvist, M. B. (2019). *" That ' s a woman ' s problem " : a qualitative analysis to understand male involvement in maternal and newborn health in Jigawa state , northern Nigeria*. 1–11.

Sialubanje, C., Massar, K., Hamer, D. H., & Ruiter, R. A. C. (2015). Reasons for home delivery and use of traditional birth attendants in rural Zambia: A qualitative study. *BMC Pregnancy and Childbirth*, *15*(1), 1–12. https://doi.org/10.1186/s12884-015-0652-7

Sinai, I., Anyanti, J., Khan, M., Daroda, R., & Oguntunde, O. (2017). *Northern Nigeria demand for services Demand for Women ' s Health Services in Northern Nigeria : A Review of the Literature*. *21*(June), 96–108.

Solanke, B. L., Oladosu, O. A., Akinlo, A., & Olanisebe, S. O. (2015). *Religion as a Social Determinant of Maternal Health Care Service Utilisation in*. *29*(2).

Somefun, O. D., & Ibisomi, L. (2016). Determinants of postnatal care non-utilization among women in Nigeria. *BMC Research Notes*, *9*(1). https://doi.org/10.1186/s13104-015-1823-3

Sumankuuro, J. (2018). *Paradoxes of f actors influencing maternal health outcomes in rural northern Ghana*. Kwame Nkrumah University of Science and Technology, Kumasi, Ghana.

Teklesilasie, W., & Deressa, W. (2020). *Barriers to husbands ' involvement in maternal health care in Sidama zone , Southern Ethiopia : a qualitative study*. *5*, 1–8.

Umar, A. S. (2017). Does female education explain the disparity in the use of antenatal and natal services in Nigeria? Evidence from demographic and health survey data. *African Health Sciences*, *17*(2), 391–399. https://doi.org/10.4314/ahs.v17i2.13

Wanjala, S. (2016). Maternal Healthcare Services Utilization : Determinants of Maternal Healthcare Services Utilization in a resource poor setting. *Resarch Gate*, *102*(October 2021), 1–102.

WHO. (2019). *Maternal mortality*. https://www.who.int/europe/news-room/fact-sheets/item/maternal-mortality

WHO. (2021). *Cardiovascular diseases (CVDs)*. https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds)#:~:text=Cardiovascular diseases (CVDs) are the,- and middle-income countries.